ABC of Dermatology

P K BUXTON

TREATMENT OF ECZEMA AND INFLAMMATORY DERMATOSES

(1) Treat the patient, not just the rash

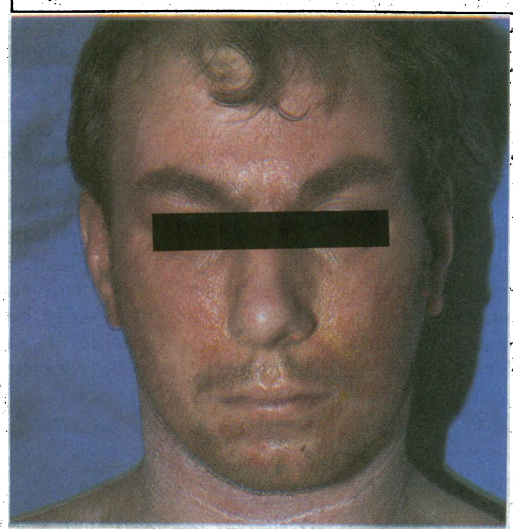
(2) Avoid promising complete cure

(3) Be realistic about applying treatments at home

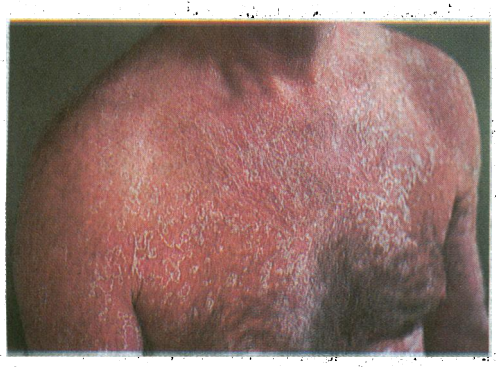
(4) Make sure the patient understands how to carry out the treatment

(5) Advise using emollients and minimal soap

(6) Provide detailed guidance on using steroids



Weeping eczema



Acute erythema

Treat the patient, not just the rash. Many patients accept their skin condition with equanimity but others suffer much distress—especially if the face and hands are affected. Acceptance by the doctor of the individual and his or her attitudes to the disease goes a long way to helping the patient live with the condition.

The common inflammatory skin diseases can nearly always be improved or cleared—but it is wise not to promise a permanent cure.

Be realistic about the treatment people can apply in their own homes. It is easy to unthinkingly give patients with a widespread rash a large amount of ointment to apply twice daily, which is hardly used because: (*a*) they have a busy job or young children and simply do not have time to apply ointment to the whole skin; (*b*) they have arthritic or other limitations of movement and can reach only a small part of the body; (*c*) the tar or other ointment is smelly or discolours their clothes. Most of us have been guilty of forgetting these factors at one time or another.

Dry skin tends to be itchy, so advise minimal use of soap. Emollients are used to soften the skin, and the simpler the better. Emulsifying ointment *BP* is cheap and effective but rather thick. I advise patients to mix two tablespoons in a kitchen blender with a pint of water—the result is a creamy mixture that can easily be used in the bath. Various proprietary bath oils are available and can be applied directly to wet skin. This is more sensible than putting them in the bath water, which makes the bath slippery with more oil going down the drain than on the skin. There are many proprietary emollients.

Steroid ointments are effective in relieving inflammation and itching but are not always used effectively. Advise patients to use a strong steroid (such as betamethasone or fluocinolone acetonide) frequently for a few days to bring the condition under control; then change to a weaker steroid (dilute betamethasone, fluocinolone, clobetasone, hydrocortisone) less frequently. Strong steroids should not be continued for long periods, and do not prescribe any steroid stronger than hydrocortisone for the face as a rule. Strong steroids cause florid telangiectasia and pustules. Avoid using steroids on ulcerated areas. Prolonged use of topical steroids may mask an underlying bacterial or fungal infection.

Specific treatment

Wet, inflamed, exuding lesions

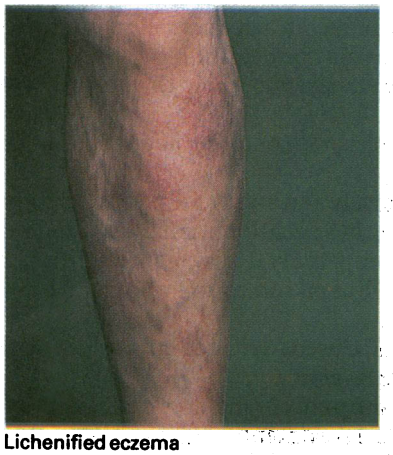
(1) Use wet soaks with normal saline or aluminium acetate (0·6%). Potassium permanganate (0·1%) solution should be used if there is any sign of infection.

(2) Use wet compresses rather than dry dressings.

(3) Steroid *creams* should be used as outlined above. Greasy ointment bases just float off on the exudate.

(4) A combined steroid-antibiotic cream is often needed as infection readily develops.

(5) Systemic antibiotics may be required. Take swabs for bacteriological examination first.



Lichenified eczema

Dry, scaling, lichenified lesions

(1) Use emollients.

(2) Use steroid *ointments*, with antibiotics if infection is present.

(3) A weak coal tar preparation or ichthammol can be used on top of the ointments. This is particularly useful at night to prevent itching. 1-2% Coal tar can be prescribed in an ointment. For hard, lichenified skin salicylic acid can be incorporated and the following formulation has been found useful in our department: coal tar solution *BP* 10%, salicylic acid 2%, and unguentum drench to 100%. 1% Ichthammol and 15% zinc oxide in white soft paraffin is less likely to irritate than tar and is suitable for childen.

(4) In treating psoriasis start with a weaker tar preparation and progress to a stronger one.

(5) For thick, hyperkeratotic lesions, particularly in the scalp, salicylic acid is useful. It can be prescribed as 2-5% in aqueous cream, 1-2% in arachis oil, or 6% gel.

It is often easiest for the patient to apply the preparation to the scalp at night and wash it out the next morning with a tar shampoo.

Hand dermatitis

Hand dermatitis: hints on management

(1) Hand washing:
Use tepid water and soap without perfume or colouring or chemicals added. Dry carefully, especially between fingers.

(2) When in wet work:
Wear cotton gloves under rubber gloves (or plastic if you are allergic to rubber). Try not to use hot water and cut down to 15 minutes at a time if possible. Remove rings before wet or dry work. Use running water if possible.

(3) Wear gloves in cold weather and for dusty work.

(4) Use only ointments prescribed for you.

(5) Things to avoid:
(a) Shampoo
(b) Peeling fruits and vegetables, especially citrus fruits
(c) Polishes of all kinds
(d) Solvents—eg, white spirit, thinners, turpentine
(e) Hair lotions, creams, and dyes
(f) Detergents and strong cleansing agents
(g) "Unknown" chemicals.

(6) Use "moisturisers" or emollients which have been recommended by your doctor—to counteract dryness.

Hand dermatitis poses a particular problem in management and it is important that protection is continued after the initial rash has healed since it takes some time for the skin to recover its barrier function. Ointments or creams should be reapplied each time the hands have been washed.

It is useful to give patients a list of simple instructions such as those shown here.

Management of pruritus (itching skin)

Causes

Endocrine diseases—Diabetes, myxoedema, hyperthyroidism.
Metabolic diseases—Hepatic failure, chronic renal failure.
Malignancy—Lymphoma, reticulosis, carcinomatosis.
Psychological—Anxiety, parasitophobia.
Tropical Infection—Filariasis, hookworm.
Drugs—Alkaloids.

Scratching the skin produces lichenification so that it is not always possible to know if there was originally an underlying area of eczema or a primary itching condition of the skin.

Endogenous eczema can produce severe itching, often made worse by secondary infection. Irritants or allergens also cause an intense itching and should be suspected, particularly if the eyelids or hands are affected.

Scabies causes intense itching and can be overlooked. Take scrapings for mycological examination. In the absence of any other apparent condition remember the causes of pruritus shown in the box.

Treatment—The object of symptomatic treatment is to break the "itch-scratch-itch" cycle once the cause has been eliminated. Topical steroid ointments and occlusive dressings help to prevent scratching.

Investigations
- Skin scrapings for mycology
- Patch testing for allergies
- Full blood count, erythrocyte sedimentation rate, liver and renal function tests
- Urine analysis
- Stools for blood and parasites

Use emollients for dry skin.

Topical local anaesthetics give relief but can cause allergic reactions.

Sedative antihistamines at night may be helpful.

In liver failure cholestyramine powders may help to relieve the intense pruritus that can occur.

Pruritus ani is a common, troublesome condition and the following points may be helpful.

(1) Patients often wash obsessively and attack the perianal area frequently with soap and water. Advise gentle cleaning, once daily.

(2) Avoid harsh toilet paper—especially if it is coloured (cheap dyes irritate and can cause allergies). Olive oil and cotton wool can be used instead.

(3) Weaker topical steroids can be used to reduce inflammation with zinc cream or ointment as a protective layer on top.

(4) Anal leakage from an incompetent sphincter, skin tags, or haemorrhoids may require surgical treatment.

(5) There may be anxiety or depression but pruritus ani itself can lead to irritability and depression.

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Portraits from Memory

22—Dr Samuel Tertius Cowan (1905-76)

JAMES HOWIE

Sam Cowan became a leading and greatly respected international figure in bacterial nomenclature and taxonomy—unlikely subjects for a medical graduate. It was not the career that he had originally planned for himself, but he made a great success of it and won for the subject a far wider interest than either he himself or any of his medical colleagues would at first have thought possible. Sam prided himself on being "a Manchester man. This means that I'm direct. If I see a thing as right I go for it—no matter what." In 1926 he had the name Tertius added by deed poll because he was the third Sam Cowan. In this he was being direct and logical, but unusual in that he greatly disliked Latin and endured learning it only because, in 1924, it was a required subject for entry to a medical course at Manchester University. Oddly enough correct use of the "dead" language was an important part of getting bacterial nomenclature exactly right. Sam remained impatient at its minutiae but nevertheless insisted on getting them right.

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He graduated in 1930 from Manchester University; but it was not long before Sam decided that a clinical career was not for him and he embarked on research in bacteriology. He found this to his liking, enjoyed the intellectual and friendly company he found in laboratories, and was well on his way as a lecturer in bacteriology at Manchester and as a Freedom research fellow in London when the war came and Sam joined the RAMC as a laboratory specialist with the rank of major.

Sam's war was an exciting and a dangerous one. He escaped from Greece in 1941 with no time to spare, and he was in Crete and Tobruk when these were anything but safe places. In 1943 he returned to England and served at the Royal Herbert Hospital, Woolwich, and for a time at the War Office. When the war ended he decided after due thought that an academic career was not the one that might suit him best, and, in 1947, he became curator of the National Collection of Type Cultures, then housed at the Lister Institute at Elstree. He soon embarked on a necessary major reorganisation which was greatly assisted in 1949 when the collection moved to the Central Public Health Laboratory at Colindale, where improved, although not perfect, facilities were available. He introduced freeze drying as the main method of preservation and started the detailed records of the collection that made it one of the foremost in the world. These new records were later used for analysis by methods not then thought of.

What's in a name

A substantial part of Sam Cowan's effort went to international affairs, particularly in bacterial systematics. In 1950 he became permanent secretary for medical microbiology of the international committee on bacteriological nomenclature. In addition to many other international contributions he had a powerful influence on the eighth and most recent edition of *Bergey's Manual of Determinative*